

**ASSESSMENT PLAN FOR AFC RESIDENTS**  
Michigan Department of Consumer and Industry Services  
Division of Adult Foster Care Licensing

**INSTRUCTIONS:**

1. A written assessment plan is required. The licensee is responsible for assuring that a written assessment plan is completed.
2. This form has been approved by the Department of Consumer and Industry Services and contains the information required by administrative rule and Section 3 (9) of Act 218, P.A. 1979, as amended.
3. This form is to be completed by the licensee and resident, or the resident's designated representative. The responsible agency, if any, may assist in this process.
4. Use additional sheets if necessary and **PRINT CLEARLY.**

Name of Resident	Name of Designated Representative (if applicable)	Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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**I. SOCIAL/BEHAVIORAL ASSESSMENT      PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF NO, Describe Needs and How They Will Be Met
A. Moves Independently in Community			
B. Communicates Needs			
C. Understands Verbal Communication			
D. Alert to Surroundings			
E. Reads and Writes			
F. Tells Time			
G. Manages Money			
H. Follows Instructions			
I. Controls Aggressive Behavior			
J. Controls Sexual Behavior			
K. Gets Along With Others			
L. Exhibits Self Injurious Behavior			
M. Participates in Social Activities			
N. Smokes			
O. Appropriately Uses Alcohol/Drugs			

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See Page 4 for Non-discrimination and ADA statement.

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**II. SELF CARE SKILL ASSESSMENT****PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Needs Help		IF YES , Describe Needs and How They Will Be Met
	Yes	No	
A. Eating/Feeding			
B. Toileting			
C. Bathing			
D. Grooming (hair care, teeth, nails, etc.)			
E. Dressing			
F. Personal Hygiene			
G. Walking/Mobility			
H. Stair climbing			
I. Use of Prosthesis (Dentures, Artificial limbs, etc.)			
J. Use of Assistive Devices (explain)			
K. Other (explain)			

**III. HEALTH CARE ASSESSMENT****PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

	Yes	No	IF YES , Describe Needs and How They Will Be Met
A. Taking medication			
B. Special Diets			
C. Physical Limitations			
D. Special Equipment Used (Wheel chair, Walker, Cane, etc.)			
E. Other Difficulties (Vision,Weight, Allergies, etc.)			
F. Susceptible to Hypothermia or Hyperthermia			

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**IV. SOCIAL AND PROGRAM ACTIVITIES****PLAN OF ACTION (Check Yes or No and Complete Where Appropriate)**

			<b>Explain How These Activities Will Be Provided or Encouraged</b>
	<b>Yes</b>	<b>No</b>	
A. Participates in Religious Practice			
B. Participates in Household Chores			
C. Adult Activity Program			
D. Senior Center			
E. Workshop or job			
F. School			
G. Hobbies/Special Interest			
H. Recreation			
I. Physical Exercise			
J. Family/Friends (Please Address Any Applicable Visitation Prohibitions and/or Other Considerations)			
K. Other (explain)			

**V. MEDICAL INFORMATION**

Name of Primary Physician/Clinic		Telephone Number (     )	
Primary Physician's Complete Address (Street Number and Name)	City	State	Zip Code

**MEDICATIONS TAKEN AT TIME OF ASSESSMENT**

<b>Name of Medication</b>	<b>Who Prescribed</b>	<b>Dosage</b>

CONTINUED ON NEXT PAGE

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**MEDICAL OR DENTAL FOLLOW-UPS NEEDED ( i.e., check-ups, regular appointments, etc.)**


**VI. RELEASE OF INFORMATION - RESIDENT OR LEGAL GUARDIAN SIGNATURE ONLY**

“ By signing this form, I understand that I am authorizing the release of medical information concerning me, including information regarding Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV), if applicable, to the licensee and licensee's staff, the responsible agency and the Michigan Department of Consumer and Industry Services, Bureau of Regulatory Services, for the purpose of providing appropriate care to me and determining compliance with licensing rules. “

Signature of Resident or Legal Guardian:

Date:

**VII. OTHER INFORMATION**

Comments/Special Instructions:

**VIII. ASSESSMENT PLAN COMPLETION**

Date Assessment Plan Was Completed

Name(s) and Position(s) of Person(s) Who Completed Assessment

**IX. PLACEMENT OBJECTIVE****A.** ☐ Delay/prevent deterioration and movement to a more restrictive setting.**B.** ☐ Encourage movement to a less restrictive setting.**X. SIGNATURES**

Signature of Resident or Designated Representative

Date

Signature of Licensee

Date

Signature of Responsible Agency (if applicable)

Date

**AUTHORITY:** Act 218 P.A. 1979, as amended**COMPLETION:** Voluntary**PENALTY:** Violation of Administrative Rule and Act 218  
P.A. 1979, as amended

The Department of Consumer and Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.